HM Coroner
The Coroners Courts & Office
The Guildhall
Alfred Gelder Street
Kingston upon Hull
HU1 2AA

01 August 2024

Dear HM Coroner (Mrs Sally Robinson, Assistant Coroner)

Regulation 28 Report following the inquest into the death of Mrs Heath

We provide the formal response of the Care Quality Commission (CQC) to the Regulation 28 Preventing Future Deaths report made by HM Coroner (Mrs Sally Robinson, Assistant Coroner) following the inquest into the death of Mrs Heath. ('the Regulation 28 Report').

In the Regulation 28 Preventing Future Deaths report HM Coroner raised the following concerns:

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) The Immediate Discharge Summary did not include relevant or sufficient information about treatment in the community needs or a nursing summary.

(2) Despite the presence of a difficult sacral sore which would have benefitted from district nursing care, no referral was made post discharge by the GP surgery.

(3) No trigger appears to exist whereby GPs conduct follow up enquiries or visits to patients who have recently been discharged from hospital and who are complaining of a condition which may worsen and failing to attend routine appointments due to a worsening of their condition.

(4) An over reliance upon private hygiene care packages with insufficient inquiry into the parameters of care provided by the private domiciliary carers.

Hull University Teaching Hospitals NHS Trust

NHS trust's do not report deaths to CQC, and we first became aware of the death of Mrs Heath on 10 May 2024 from your prevention of Future Death Report where we were a named responder.

Following receipt of this report CQC held a management review meeting and agreed to request the inquest medical evidence bundle. In addition, we asked Hull University Teaching Hospitals NHS Trust to provide evidence of any action they had taken to date following the tragic death of Mrs Heath. We reviewed all the information obtained by the CQC and concluded there were no grounds to suspect a criminal offence.

The trust's last comprehensive inspection was in November 2022 and the report was published in March 2023. CQC rated the trust as "Requires Improvement."

A copy of the report can be found on our website - Trust - RWA Hull University Teaching Hospitals NHS Trust (23/03/2023) INS2-13905362001 (cqc.org.uk)

CQC hold monthly engagement meetings with the trust to ensure that the fundamental standards of quality and safety are being met. At this meeting we review the trust's progress on their post inspection action plan and ensure improvements made are sustainable and embedded.

Since Mrs Heath's death in March 2022 the trust have completed a number of actions relating to the management of pressure ulcers to eliminate the risk of this happening again.

- Mandatory training compliance levels for tissue viability for registered and non-registered nursing and midwifery teams are reported monthly to the safer skin committee. Tissue viability training now includes national e-learning modules, trust e-learning training videos in recognising and treating of moisture associated skin damage and chronic wound assessments.

- Audits for tissue viability and ward assurance are reported monthly to the safer skin committee who monitor any recommendations actions required and check compliance against an evidence based framework.

- Introduction of a senior nurse to regularly review patients who have moderate to high risk pressure sores. They ensure all members of the multidisciplinary team are involved in the patient care as needed. Referrals can be made to the tissue viability teams as well as plastic surgery. They are responsible for arranging onward referrals to district nursing teams and arranging appropriate equipment prior to discharge.

- Updated standard operating procedures for digital wound photography to include photographs of wounds on admission, when transferred to a clinical areas to identify improvements / deterioration of wound appearance.

- Monthly meetings with community health care partnership (CHCP) to work in partnership to improve communication for discharges and transfers of care across both healthcare providers.
- Clinical areas now display monthly posters for the number of days they have been “pressure ulcer free”.

- Updated standing operating procedures for ordering equipment such as dynamic mattresses.

- Updated patient information leaflet “preventing pressure ulcers – working together with patients and carers to prevent pressure ulcers”.

St Andrew’s surgery at Elliott Chappell Health Centre

CQC inspected St Andrew’s surgery at Elliott Chappell Health Centre in November 2017. The report was published in January 2018 and it was rated as good.

A copy of the report can be found on our website - Elliott Chappell Health Centre NewApproachComprehensive Report (GPPractices Location Oct 2017)_INS2-3890813910 (cqc.org.uk)

City Health Care Partnership

CQC inspected Community health services for adults in November 2016 and rated it as good.

In June 2022 we carried out a focussed inspection based upon the quality of management of wound care within the Hull and East Riding community nursing service. The inspection did not look at other services provided by City Health Care Partnership or other areas of the community nursing service. This inspection was not rated, which meant the existing rating of good remains in place. CQC did not identify any required enforcement action during this inspection.

A copy of the report can be found on our website - Core Service - Community health services for adults - (28/11/2022) INS2-12629169601 (cqc.org.uk)

A national professional advisor and senior specialist for Primary and Community Care at CQC have reviewed the coroner’s letter, evidence bundle, the clinical records and practice response to the integrated care board who would cover the oversight of this GP practice. The findings will be shared with the operations team for Primary and Community Care to consider alongside other information held by CQC. This will inform our regulatory response.

During the inspection process we routinely review correspondence, tasks and referrals. We will use the regulation 28 report to remind colleagues of the importance of this process.

There will be ongoing monitoring of this provider via our monitoring and inspection process.

In addition to our inspection activity, CQC continually monitors all the information we hold about services for any themes and trends. We review intelligence data from a range of sources. For example, for trust's we look at incidents reported to National Reporting and Learning System (NRLS) and Strategic Executive Information Systems (StEIS). This will now include incidents reported to the "Learn from Patient Safety Events" system (LPSIR). We also receive information from local authority safeguarding teams and attend meetings safeguarding meetings. We also engage with other regulators (such as the Environmental Health Agency or local Clinical Commissioning Groups) and Fire and Rescue Services or the Police.

CQC receive information directly from patients or relatives of people who use services. This is extremely valuable to us as they are best placed to know whether they / their relative received safe, compassionate, and high-quality care.

CQC also receive information from whistle-blowers (serving or former members of staff).

If the CQC receives any information of concern about a service our aim is to respond as quickly as possible, assessing the risk using our new single assessment framework methodology and identifying the appropriate action to take. We will use our enforcement powers if regulations are not being met.

CQC will discuss the concerns you have raised about Mrs Heath's death at our next engagement meeting with the Hull University Teaching Hospitals NHS Trust. If we are not assured that improvements have been made, we will make an appropriate regulatory response.

CQC's next inspection of these services are not yet confirmed, however we have adopted a more risk based approach to inspections should CQC receive negative intelligence or have further concerns about the service we would carry out responsive inspections.

CQC hope that this response addresses your concerns.

Yours sincerely

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[redacted]

Deputy Director of Operations

Network North